

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-042446

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED OCT 18 1963

I. PLACE OF DEATH

a. COUNTY

St. Louis

b. CITY (if outside corporate limits, give TOWNSHIP only)
OR
TOWN

Richmond Hts.

Length of stay in 1b
1 Hr.

c. FULL NAME OF (if NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

St. Mary's Hospital

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

Inside Limits
Yes ☒ No ☐

c. CITY
OR
TOWN

St. Louis

d. STREET
ADDRESS

(If outside, give location)
4707 Wilcox Ave.

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First
HERMAN

Middle
T.

Last
SUREN

4. DATE
OF
DEATH

Month

Day

Year

Oct. 6

1963

5. SEX
Male

6. COLOR OR RACE
White

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

2-26-1893

9. AGE (last birthday)

70

IF UNDER 1 YEAR
Months Days Hours Min.

IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Stationery Engineer

10b. KIND OF BUSINESS OR INDUSTRY

Falstaff Brewery

11. BIRTHPLACE (City and state or country)

St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Herman Suren

13b. MOTHER'S MAIDEN NAME

Katherine Schweer

14. NAME OF HUSBAND OR WIFE

Rose Ann Suren

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give year or dates of service)

Yes

World War I

17. INFORMANT

Address

Rose Ann Suren 4707 Wilcox Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH
24 hr

DUE TO (b)

Atherosclerotic Heart Disease

20+ years

DUE TO (c)

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Probable Rheumatic Ht. Disease

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

7-13-63 to 10-6-63 and last saw her alive on 10-6-63
10:00 P.

22a. SIGNATURE

James F. M. Coolidge

22b. ADDRESS

3915 Watson Rd

22c. DATE SIGNED

10-6-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

Oct. 9, 1963

23c. NAME OF CEMETERY OR CREMATORY

National Cemetery

23d. LOCATION (City, town, or county)

Jefferson Barracks, Mo.

24. FUNERAL DIRECTOR

ADDRESS

Kriegshauser 4228 S. Kingshighway

25. DATE RECD. BY LOCAL REG.

10-7-63

26. REGISTRAR'S SIGNATURE

John B. Murphy

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

DATE AMENDED

2

3

4

5

6

7

8

9

10

11

12

13

46-0

46

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed RW Steward

Licensed Embalmer No. 4007

P. O. Address St. Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.